1. Introduction

One of the central goals of the Patient Protection and Affordable Care Act (ACA) is to extend health insurance to the uninsured and improve access to affordable health care. Two of the main ways that ACA extends health care coverage are through the expansion of public insurance and modifications to the private health insurance market, including the establishment of health insurance marketplaces or exchanges. Although the ACA is national in its scope, much of the critical action is taking place at the state level.

ACA expands public insurance by allowing states to extend Medicaid eligibility to individuals with an income below 138 percent of the federal poverty level (FPL) and offering federal subsidies to states to cover most of the costs associated with insuring those newly eligible for public insurance (RAND Corporation, 2014).

The ACA also allows states to establish their own exchanges, also known as state-based marketplaces, to facilitate the purchase of health insurance for eligible individuals and small businesses (Kaiser Family Foundation, April 2013).[2] The marketplaces are intended for American citizens and legal residents who are ineligible for public health insurance (i.e., Medicaid, Children's Health Plan Plus [CHP+]) and who do not have an offer of creditable employer-sponsored health care coverage. Marketplaces are designed to make purchasing an individual health insurance plan easier by (1) standardizing offerings with bronze, silver, gold, and platinum plans that have defined actuarial values and cover, at a minimum, a number of specified "essential health benefits" and (2) increasing the transparency of price and quality differences across plans. Catastrophic health insurance plans are also available for people under 30 and people with hardship exemptions. ACA provisions require guaranteed issue and renewability of plans purchased through exchanges and remove preexisting condition exclusions and waiting periods. These provisions are intended to ensure the availability of coverage to individuals regardless of health status and expected health costs (Kaiser Family Foundation, April 2013).

The ACA provides consumers subsidies for the purchase of exchange-based plans for individuals with incomes between 100 percent and 400 percent of the FPL[3] who are ineligible for Medicaid and have no affordable employer offer.[4] In addition, the ACA precludes insurers from

[2] States that have chosen not to facilitate their own exchanges have either partnered with the federal government to run exchanges or have federally facilitated exchanges.

[3] 2014 federal poverty levels: 138 percent is $32,913 for a family of four. Subsidies are available up to 400 percent of the FPL, which is $95,400 for a family of four. States use a modified adjusted gross income formula.

[4] The legality of affording tax credits to eligible individuals who purchased health insurance through a federal exchange is being called into question, based on an interpretation of statutory language in the ACA (the legality of tax credits for individuals who purchased health insurance through state exchanges, including Colorado, is not being

setting premiums that vary across individuals other than by age, region, family structure, and smoking status; limits the amount of variation in premium by age; and requires regulatory review of annual health insurance premium increases (Centers for Medicare and Medicaid Services, 2014b). The ACA imposes a penalty on individuals who are not covered by insurance, with some exceptions, such as for undocumented immigrants and individuals who would have to pay a premium that was greater than a specified share of their income (Kaiser Family Foundation, April 2013). The penalty in 2014 is $95 per adult and half that amount per child, up to a maximum of $280 per family or 1 percent of family income, whichever is greater (Kaiser Family Foundation, 2013a).

Covering the Uninsured in Colorado

Colorado is one of 17 states[5] with its own Marketplace (Kaiser Family Foundation, 2014) and one of 27 states that opted to expand Medicaid to low-income adults (Kaiser Family Foundation, 2014). Individuals can sign up for Medicaid or private insurance through the Health Insurance Marketplace, depending on their eligibility.

Prior to 2014, it was estimated that 737,000 individuals in Colorado were uninsured. Of these, 34 percent were Medicaid-eligible adults, 12 percent were Medicaid- or CHP+-eligible children, and 22 percent were eligible for tax-credit subsidies (33 percent were not eligible for financial assistance) (Kaiser Family Foundation, April 2014a). It is estimated that undocumented immigrants and their children account for about 4 percent of Colorado's overall population; undocumented immigrants are not eligible for Medicaid or insurance through the Marketplace (Camarota, August 2012).

Medicaid

In addition to expanding eligibility for Medicaid to up to 138 percent of the FPL in adults aged 19–64, Colorado continues to offer Medicaid to eligible children and pregnant women up to 147 percent of the FPL. Low-income children and pregnant women with household incomes up to 260 percent of the FPL and who are not eligible for Medicaid may qualify for CHP+, Colorado's state child health insurance program (Child Health Plan Plus, 2014). Colorado was an early implementer of Medicaid expansion and expanded coverage to low-income adults in 2012 under a Section 1115 research and demonstration waiver; this waiver extended Medicaid coverage to a small sample of childless adults with incomes up to 10 percent of the FPL (capped at 10,000 persons) prior to the implementation period of the ACA (Colorado Department of Health Care Policy and Financing, 2013; Courtot & Coughlin, 2013).

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debated). Two Circuits (the D.C. Circuit Court of Appeals in Washington and the 4th Circuit in Richmond, Virginia) reached differing conclusions on July 21, 2014 (James, 2014), continuing the debate over the legality of subsidies under the ACA.

[5] Including the District of Columbia.

An estimated 258,000 Colorado residents were estimated to be eligible for Medicaid but not enrolled at the start of Medicaid expansion in January 2014; 210,000 of these individuals were newly eligible based on the expanded ACA criteria (Colorado Health Institute, 2014b).

Health Insurance Marketplace

The Colorado Health Benefit Exchange was signed into law in June 2011. Colorado's online exchange, now called Connect for Health Colorado, operates as a clearinghouse in which carriers can offer plans for consumers competitively. Although carriers can also offer plans outside the exchange directly to consumers, subsidies, provided in the form of tax credits, are available only when insurance is purchased through the exchange. Connect for Health Colorado offers both an individual marketplace and a small business health options (SHOP) marketplace, which helps businesses provide health coverage to their employees. As of June 2014, ten carriers offered 242 plans on the individual market, and eight carriers offered 92 plans on the SHOP marketplace (Colorado Department of Regulatory Agencies, 2014; Kaiser Family Foundation, November 2013). In the first open enrollment period, in order to get the subsidy, applicants had to first be evaluated for Medicaid eligibility through the Program Eligibility and Application Kit (PEAK) online process. Only after denial from Medicaid could an individual apply for the tax credits for the purchase of health insurance through the Marketplace.

Outreach Overview

As part of ACA implementation, state-based marketplaces can provide several types of consumer assistance to facilitate health care coverage enrollment (Centers for Medicare and Medicaid Services, 2014a). The goal of consumer assistance is to provide outreach and education to residents to raise awareness about the Marketplace, to prepare applications to establish eligibility and enroll in coverage through the Marketplace, and to offer other application and enrollment support. State-based marketplaces, like Colorado's, offer consumer assistance through a variety of mechanisms that often overlap in function but differ in the ways in which they are funded: (1) navigators, whose training can be funded by the federal government but whose compensation is funded by state and private grants; (2) in-person consumer assistants, who have similar functions as navigators but may be supported by state-administered (federally funded) Exchange Establishment grants; (3) certified application counselors (individuals and organizations). who may be federally funded and have some of the same roles as navigators and consumer assistants but who often are situated within existing health care or social service facilities; and (4) agents/brokers, who are compensated by insurance companies or consumers, consistent with state law (Centers for Medicare and Medicaid Services, 2014a). Regardless of funding support, most states report little difference among the types of services and assistance provided to consumers—particularly between navigators and in-person assistants (Dash, Lucia, Keith, & Monahan, 2013).

In Colorado, consumer assistance is organized into the Connect for Health Colorado Assistance Network, with navigators and in-person assistants collectively referred to as health coverage guides. Connect for Health Colorado (the Colorado Marketplace) issued a request for proposals for community-based organizations to serve as assistance sites and regional assistance hubs. Regional hubs share best practices and coordinate outreach efforts across the assistance sites in their region, and some provide support and training for assistance sites throughout their region and assist with communications efforts throughout the Assistance Network. Assistance sites hire, train, and supervise health coverage guides, who perform in-person education and application assistance services. Connect for Health Colorado contracted with 54 organizations to provide services within the Assistance Network, with five of these sites also operating as regional hubs (one additional organization serves only as a regional hub). Connect for Health Colorado awarded approximately $16 million to support these efforts (Connect for Health Colorado, August 2014). Additional funding was made available through private grants, including funds from the Colorado Health Foundation. Assistance sites are composed of community/nonprofit and faith-based groups, hospitals and clinics, public health or human service organizations, and trade associations. The majority of these organizations have an established role in the communities they serve; some provide direct health care services. In addition, many community-based organizations that are not official Connect for Health Colorado assistance sites have certified health application counselors on their premises. Health coverage guides provide services at more than 75 locations throughout the state. At the start of open enrollment, the Assistance Network had 1,400 licensed and certified health insurance agents/brokers who provide advice and support with health insurance enrollment; this number had grown to over 1,500 by August, 2014 (Connect for Health Colorado, 2013; Kaiser Family Foundation, November 2013).

By the end of open enrollment (April 2013–June 2014), Colorado spent about $8 million to market its health insurance exchange (Connect for Health Colorado, August 2014). This campaign consisted of media advertisements and direct outreach, including paid (e.g., radio, television) and earned media (e.g., journalistic coverage); Internet and social media; and in-person outreach to drive interest in enrollment.

Enrollment to Date and Rationale for the Study

More than 310,000 Coloradans had signed up or were approved for health insurance by the end of the first open enrollment period (Kaiser Family Foundation, April 2014b). Between October 1, 2013, and March 31, 2014, 178,504 Coloradoans had newly enrolled in Medicaid and CHP+. During this same period, 125,402 Coloradans enrolled in Marketplace plans (U.S. Department of Health and Human Services, 2014), with 134,950 Coloradans enrolled as of May 2014 (Connect for Health Colorado, May 2014). Prior to open enrollment, the Centers for Medicare and Medicaid Services (CMS) established state targets for Marketplace enrollment; the CMS target

for Colorado was 92,000. Colorado exceeded the CMS-identified state target by more than 30 percent (Connect for Health Colorado, April 2014).

Despite this success, there continues to be a diverse mix of individuals who are eligible for but not enrolled in health care coverage. For example, Colorado's Southeast region had the lowest percentage of Marketplace enrollments among eligible individuals who qualify for a tax credit (25 percent), compared with other regions Colorado (Colorado Health Institute, 2014a). In addition, adult enrollees between the ages of 55 and 64 were more likely to enroll in Medicaid or the Marketplace than individuals between the ages of 19 and 29 (55 percent vs. 45 percent, respectively) (Colorado Department of Health Care Policy and Financing, April 2014a; Colorado Health Institute, 2014a).

The Colorado Health Foundation commissioned the RAND Corporation to conduct a study to better understand reasons why eligible individuals are not enrolled in health insurance coverage and to develop recommendations for how Colorado can strengthen its outreach and enrollment efforts during the next open enrollment period, which starts November 2014.

Study Methods

RAND engaged consumers and stakeholders involved in the policymaking and insurance enrollment process throughout the state to better understand factors affecting enrollment. This occurred through focus groups with uninsured and newly insured individuals and semistructured interviews with local stakeholders. This report focuses on individuals eligible for insurance through the Marketplace and through Medicaid. We did not emphasize views from populations ineligible to obtain insurance through these mechanisms (such as undocumented residents) or from individuals who refused employer-sponsored insurance options, although both views are important. However, some of our focus groups did include perspectives from families with mixed immigration status (mixed-status families), in which at least one person in the family is undocumented; those findings are discussed in the report.

Our key objectives were as follows:

- Examine elements of the outreach and enrollment approach and strategy.
- Explore barriers and facilitators to outreach and enrollment from both the consumer and stakeholder perspectives.
- Understand contextual or social factors contributing to or impeding success, including the social and political climates.
- Explore opportunities to improve the outreach and enrollment process.

Consumer Focus Groups

RAND engaged a total of 108 uninsured or newly insured individuals to understand their perspectives on why they had or had not enrolled in health insurance in Colorado. In partnership with the Colorado Health Foundation and using National Center for Health Statistics data,

RAND identified eight regions across Colorado to conduct consumer focus groups during the last two weeks of June 2014. The regions were originally based on those outlined by the Colorado Department of Public Health and Environment, but modified slightly to capture the North Central region (Colorado Department of Public Health and Environment, 2014) (see Appendixes A–H). Focus groups varied by insurance gaps, special populations of interest (e.g., Spanish-speaking immigrants), and location within the state (e.g., urban, rural) to capture a diverse mix of views. Three focus groups were held in Denver (n=41; one of the groups was conducted in Spanish), two in Grand Junction (n=9), two in Silverthorne (n=13 across two groups; one was conducted in Spanish), and one each in Colorado Springs (n=13), Fort Collins (n=13), Pueblo (n=11), and Sterling (n=4). In addition, we conducted four individual interviews with consumers from La Plata in lieu of a focus group, given participants' inability to attend the focus group on the designated date and time. As shown in Table 1.1, we sought to recruit a specific target demographic in each focus group to ensure representation from a diverse mix of special populations in addition to having regional representation. More information on each of the focus groups can be found in Appendixes A–H.

Focus group participants were adults younger than 65 who were either (1) eligible for but not enrolled in health care coverage in Colorado or (2) newly insured through Medicaid or the Marketplace with subsidies (e.g., signed up during open enrollment 2014). Though the emphasis of this report is on understanding reasons why individuals have not enrolled, the newly insured provided an important perspective, in that they progressed through every step needed to obtain coverage and could report on challenges with the enrollment process itself. Further, many had eligible but uninsured spouses or family. As a result, many were also able to provide a unique perspective on the barriers faced by families with mixed immigration status.

Individuals were recruited with the help of a Colorado-based recruitment firm, which disseminated information about the study in our regions of interest and conducted screeners to identify uninsured or newly insured individuals that met the preselected demographic criteria for that region (Table 1.1). We also relied on local community-based organizations for assistance in reaching Spanish-speaking individuals and other harder-to-reach populations. Host locations for the focus groups included community-based organizations or Marketplace assistance sites, a public library, and a local community college. In our focus groups, we explored a number of key themes:

- Knowledge, awareness, and understanding of health insurance
- Perceptions of health insurance
- Behaviors regarding and barriers to enrollment in health insurance
- Outreach and enrollment strategies
- Opportunities to streamline processes, remove barriers, and/or make enrollment more efficient.

Table 1.1. Composition of Focus Groups Across Colorado

Location (Region)	Spanish-Speaking	Mixed Race and Ethnicity	African American	Hispanic	Parents with Eligible Children	Younger Individuals (21–29 Years of Age)	Seasonal Workers
Colorado Springs (Central)			X	X			
Denver (Metro)			X			X	
Denver (Metro)	X			X		X	
Denver (Metro)		X					
Durango (Southwest)		X					
Fort Collins (North Central)		X				X	
Grand Junction (West Central)		X			X		
Grand Junction (West Central)		X					
Pueblo (Southeast)			X	X	X		
Silverthorne (Northwest)	X			X			X
Silverthorne (Northwest)		X					X
Sterling (Northeast)		X					

Stakeholder Interviews

In partnership with the Colorado Health Foundation, RAND identified a potential list of state and local policymakers and community organizations invested in or leading outreach and enrollment efforts at the local level. We included organizations that were assistance sites for Connect for Health Colorado in various regions.

Using a semistructured interview protocol, we completed a total of 14 30–45-minute phone-based interviews with stakeholders during the first two weeks of July 2014. In our interviews, we explored a number of key themes:

- Elements of the outreach and enrollment approach and strategy
- Populations or geographies that have responded particularly well (or not) to the approach
- Partnerships or collaborations involved in the effort and those that would strengthen the effort
- Evidence of the effectiveness of the strategy
- Administrative or logistical facilitators and barriers
- Opportunities to streamline processes, remove barriers, and/or make enrollment more efficient.

In this report, we present our findings. We used content analysis to analyze themes and identify meaningful quotes from the stakeholder interviews and consumer focus groups (Krippendorff, 2012). In Chapter Two, we discuss general barriers and challenges to enrollment

that existed universally across the state. Chapter Three provides findings specific to a number of special populations. Chapter Four presents our recommendations and conclusions. Given the diversity of Colorado in terms of populations and local context, we present findings by region in Appendixes A–H. It is important to note that while the locations of the focus groups were selected to be largely representative of that region, we conducted at most three focus groups in any one region, and as a result the findings and recommendations should supplement, not supplant, local knowledge of outreach and enrollment efforts.